Payment form

MedLab PATHOLOGY

Requesting doctor _____

Requesting doctor code _____

Patient name _____

Patient DOB _____

Contact no. _____

Email address for receipt _____

Test _____

Amount _____

Method of payment ☐ Cheque / PO / Bank draft

☐ Credit / Debit card*

**For Credit/Debit card payment, please complete the information below.*
*If using a postal pack please call **1800 303 349** to pay over the phone if that is your preference.*

Name on card _____

Card type _____

Card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Start date _____ Expiry date _____ CCV _____

I hereby authorise MedLab Pathology to charge my account the amount of € _____

Signed _____ **Date** _____